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**14. ABSTRACT** This study examined the current level of palliative care services at the Minneapolis Veterans Affairs Medical Center (MVAMC). The findings of this study suggest that current palliative care services do not fully meet the palliative care needs of the existing population. Using selected strategic planning tools, this study examined the gaps in services by gathering staff opinion, examining local statistics regarding end-of-life care, and looking at community and national trends. Suggested strategic alternatives include staff development, a palliative care fellowship, and increased inpatient palliative care beds coupled with case finding and consultation provided by an interdisciplinary team. Early identification of patients appropriate for palliative care will require an integrated approach across medical teams and specialties.

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U.S. Army-Baylor University Graduate Program in Health Care Administration  
Graduate Management Project

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## Abstract

This study examined the current level of palliative care services at the Minneapolis Veterans Affairs Medical Center (MVAMC). The findings of this study suggest that current palliative care services do not fully meet the palliative care needs of the existing population. Using selected strategic planning tools, this study examined the gaps in services by gathering staff opinion, examining local statistics regarding end-of-life care, and looking at community and national trends. Suggested strategic alternatives include staff development, a palliative care fellowship, and increased inpatient palliative care beds coupled with case finding and consultation provided by an interdisciplinary team. Early identification of patients appropriate for palliative care will require an integrated approach across medical teams and specialties.

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## Introduction

In 2001 the Institute of Medicine (IOM) published a seminal report on palliative care for cancer patients. The IOM authors concluded that many patients suffer needlessly painful deaths due to a number of barriers regarding optimal end-of-life care (Institute of Medicine [IOM], 2001). One prominent barrier is the neglect from within the field of medicine to end-of-life care. This is dramatically illustrated by the fact that the National Cancer Institute spends less than one percent of its budget on research and training in end-of-life palliative care (IOM, 2001). Additional barriers exist to planning for optimal end-of-life care. Reimbursement structures often do not align with high quality palliative care, hospice rules can be confusing, and the culture of medicine is oriented towards curative approaches rather than the management of chronic illness and end stage disease (Greiner, Buhr, Phelps, & Ward, 2003). Finally, end-of-life care in acute settings is generally not standardized like other medical specialty practices (Smith, Coyne, Cassel, Penberthy, Hopson, & Hager, 2003). A study, funded by the Robert Wood Johnson Foundation, on end-of-life care indicated that while 70% of people report a preference for dying at home, only 25% of people actually die at home (Last Acts, 2003). Approximately 50% of all deaths occur in hospitals, yet 40% of hospitals across the nation report no specialized palliative or end-of-life care. Perhaps most troubling is the finding that over 50% of terminally ill cancer patients in intensive care units (ICUs) report severe pain, discomfort, and anxiety (Last Acts, 2003). Thus, end-of-life medical care appears to be poorly standardized, expensive, and often inadequate in meeting the medical and psychosocial needs of patients.

*Conditions That Prompted the Study*

Currently, end-of-life care in most institutions is a medical afterthought as opposed to a highly planned medical event. The Department of Veterans Affairs (DVA), as the largest health care system in the nation, has a unique opportunity to assist in shaping national policy and practice for end-of-life care.

In the coming decades, national health care challenges will include caring for an aging population with an increasing life expectancy and an increasing incidence of chronic illness. Health care must be provided in innovative, cost effective, and high quality ways. The Veterans Health Administration is responsible for provision of high quality medical care to the eligible veteran population. Studies of this eligible group suggest that it is more medically ill and complex than a comparison population served by the private sector. Thus, high quality and cost effective end-of-life care methods are of vital importance to the Veterans Health Administration. In fiscal year (FY) 2001 over 27,000 veterans died in Veterans Affairs (VA) facilities. Deaths of veterans are expected to significantly increase over the next several years due to the aging of the veteran population (Department of Veterans Affairs [DVA], 2002).

In 2002, The Department of Veterans Affairs reported the results of a survey examining the state of palliative care within the VA system. The survey results indicated wide variability within the VA system in terms of palliative and end-of-life care. The survey results also indicated that very few VA facilities offered comprehensive, interdisciplinary, team-based services for palliative care - - services that constitute the benchmark of excellence (DVA, 2002). The survey results did indicate that hospice and palliative care programs were growing within the VA system. The wide variability within

the VA system in terms of palliative care suggests a lack of clinical and administrative planning, as opposed to variability based solely on patient demographic differences. Additionally, the study found that even where palliative care programs existed, there was most often a passive approach (receiving consults) rather than an active, case-finding approach. The researchers concluded that palliative care is underutilized, that there is a lack of active training in and teaching about palliative care, and that systematic research is limited. A consequent recommendation by the Department of Veterans Affairs was that each facility must plan in accordance with the population it serves, keeping in mind the attributes of excellence suggested by studies in palliative care. Finally, the DVA concluded that local leadership and championing will be vitally important to introducing excellent palliative care services, teaching, and research into the hospitals and clinics within the VA health care system (DVA, 2002).

#### *Statement of the Problem*

The Minneapolis Veteran Affairs Medical Center (MVAMC) is a large, affiliated, tertiary care teaching facility. Could the utilization of strategic planning tools provide the necessary structure to assist the MVAMC in identifying gaps in palliative care provision and planning for optimal palliative care services?

Some local patient statistics highlight the need for enhanced or expanded palliative care services at the MVAMC. In FY 2003, 214 patients died while receiving inpatient care at the MVAMC. Forty percent of those patients died while on a surgical or medical intensive care unit (ICU). Of the 214 patients, only seven received palliative care consultation as part of their care (D. Zimmer, personal communication, September 2004). In 2004, 45% of the 204-inpatient deaths occurred in the ICUs in the MVAMC.

Currently, the MVAMC has two beds dedicated for palliative care. These palliative care beds are located on extended care units. Planning for palliative care occurs primarily within small functional units (such as extended care or medical intensive care) within the MVAMC, rather than across functional units or on an institution wide basis. Central Office (headquarters) in the Veterans Health Administration has deemed palliative care an urgent and unmet need in the VA system and has charged VA health systems across the country to improve and enhance palliative care services to veterans. Yet, the authors of the recent national DVA survey on palliative care noted the difficulty with estimating the need for palliative care services, in part due to the lack of active case-finding, even in institutions with palliative care programs (DVA, 2002).

### *Literature Review*

End-of-life care delivered within the United States' public or private medical systems suffers from well-documented and serious deficiencies (Casarett, Hirschman, Coffey, & Pierre, 2002). Barriers to optimal end-of-life care include lack of knowledge and poor communication among providers, patients, and family members. Additional barriers include lack of knowledge by providers about pain and symptom control, inadequate education regarding medical care of dying persons, and faulty reimbursement mechanisms (Greiner, Buhr, Phelps, Ward, 2003; Porter-Williamson, Von Guten, Garman, Herbst, Bluestein, & Evans, 2004). A senior researcher at the Rand Corporation estimates that Medicare will cover 80% of U.S. citizens when they die, and that medical expenses will explode at the end-of-life (Lynn, 2003). But what is gained from this extremely costly end-of-life care? End-of-life care is often neither reliable nor supportive in a way that takes into account the true needs of the patient in his or her final months,

weeks, and moments (Lynn, 2003). Consensus is emerging in the medical community and in accrediting organizations such as Joint Commission on Accreditation for Healthcare Organizations (JCAHO) with regard to core principles for end-of-life care (Cassel & Foley, 1999). Core principles for end-of-life care include alleviation of pain; continuity in the care of patients; respect for the final wishes of patients; and attention to the physical, psychological, and spiritual needs of patients. The American Medical Association (AMA) in a policy statement in 1997 submitted eight elements of quality care for terminal patients. These elements are: the opportunity to discuss end-of-life planning and care; the incorporation of the goals of the dying person; the assurance that there will be no physician abandonment; the assurance that preferences for discontinuing care will be honored; the assurance that dignity will be a priority; the assurance that comfort measures will be secured; the assurance that the burden to the family will be minimized; and the assurance that care providers will assist the bereaved in the early phases of their loss. The AMA suggests that central elements of high quality end-of-life care include patient-centered compassionate care and an emphasis on the dignity and humanity of the dying patient (Cassel & Foley, 1999).

While the VA has a long tradition of using hospice care for patients, there are limitations to the hospice model that necessitate complementary forms of palliative care. Patients with a terminal illness other than cancer, such as congestive heart failure, may have a far less predictable course towards death, making use of hospice more difficult (DVA, 2002). Palliative care offers the potential for meeting patients' needs on a physical and psychosocial level and can be introduced from the moment of diagnosis. The IOM suggests that palliative care is on a continuum over the course of a progressive disease

and becomes more prominent as the individual advances towards death. Thus, palliative care differs from hospice care. Ideally, palliative care should co-exist with care aimed at curing illness from the initial diagnosis of any disease. Palliative care takes on an increasingly prominent role as the disease progresses and as curative care diminishes in utility (IOM, 2001). Hospice care requires a person to formally and explicitly discontinue efforts at curative care and requires a physician to estimate the length of time left in the patient's life (Government Accountability Office [GAO], 2000). Thus, palliative care offers complementary benefits and is a vital partner to hospice care.

Despite the recognition of the importance of palliative care in improving end-of-life care, recent wide-ranging surveys of palliative care services in different parts of the country (Wisconsin and California) suggest that palliative care services are underrepresented (Pantilat & Billings, 2003; Greiner, Buhr, Phelps, & Ward, 2003). Of hospitals sampled in California fewer than 25% had a palliative care services (inpatient or consultation). In California, hospice and bereavement services were more prevalent than palliative care services and may offer the venue for further palliative care expansion (Pantilat & Billings, 2003). In Wisconsin, few institutions had access to specialists in palliative care. Additionally, the authors noted that while most deaths occur within the hospital setting, most end-of-life resources are directed outside the hospital setting (hospice and home health). "Because the majority of deaths occur in the hospital setting, these findings suggest that end-of-life care services remain most prominent outside the setting in which they are most needed" (Greiner, Buhr, Phelps, & Ward, 2003, p 549).

Although serious barriers to palliative care services currently exist, there are numerous studies that clearly demonstrate its cost efficiency in the acute care setting

(Cowan, 2004; Elsayem, Swint, Fisch, Palmer, Reddy, Walker, et al., 2004; Walsh, 2004). Patients that will most benefit from acute, inpatient palliative care services are those patients that are in advanced phases of an illness such as cancer, with numerous medical and psychosocial co-morbidities. Patients with severe symptoms in an end stage illness, who are treated in an acute palliative care inpatient setting will benefit from the interdisciplinary and comprehensive treatment approach of palliative care and will at the same time incur fewer costs than patients treated in the ICU (Elsayem, et. al, 2004).

Veterans Health Affairs (VHA) studies have suggested that significant variations exist among the Veterans Integrated Service Networks (VISNs) in terms of percentage of inpatients receiving end-of-life care in the ICUs. National cost estimates suggest that the cost per day of care in the ICU for a patient in the terminal phase of an illness, in 2001, was approximately \$1,695. One VISN calculated terminal care costs in hospice versus non-hospice inpatient beds and calculated the average cost per day as double in non-hospice beds (VHA Office of Academic Affiliations, 2002).

The scarcity of palliative care services across the nation presents a very ripe opportunity for meaningful improvement in most health care systems. Currently, studies examining palliative care review a broad range of services. Moreover, palliative care may be delivered to patients by a consultation team, an outpatient clinic team, or by an acute or extended care inpatient team (Casarett, et al, 2002; Greiner, et al., 2003; Smith, et al., 2003). The conclusions from a recent review of palliative care studies that examined costs suggested that in all studies conducted thus far, palliative care services decrease hospital costs (via decreased length of stays and judicious use of technology) without increasing mortality (Von Gunten, 2002). Planning for end-of-life care means

understanding the differences in the manner in which we die. Studies suggest that hospice has worked well with cancer patients, in part because cancer patients often stay quite functional until their disease overwhelms them, and then they die within weeks or months (Lynn, 2003). The frail, elderly, dying of organ failure, or complications of dementia with other medical co-morbidities, may endure functional declines spanning many years. Patients with this disease trajectory require daily help, continuity of care, and aggressive control of symptoms (Lynn, 2003). Different populations will be served by different models of end-of-life care delivered in a variety of venues.

The federal government is in an ideal position to lead the movement towards improved end-of-life care. It occupies the role of insurer of the majority of people at life's end. It also occupies the role of health care provider in the largest health system in our nation (Lynn, 2003). Yet, the VHA has noted in a recent self-study that wide variability exists in the approaches to end-of-life care, and that within the VHA there is a lack of planning, clinical service, teaching and research associated with palliative care (DVA, 2002). National leadership of the VHA categorizes palliative care as an urgent and unmet need. Improved palliative care services within the VHA are critical to meeting the mission of the organization.

#### *Statement of Purpose*

Would a substantial number of patients receiving end-of-life care in the ICUs at the MVAMC would be better served medically, psychologically, and ethically by a dedicated inpatient palliative care unit or enhanced palliative care in an alternative setting? Would the utilization of an active case finding system assist planners in identifying the scope of palliative care needs at the MVAMC while identifying patients



appropriate for palliative care? What are the specific advantages and disadvantages faced by the MVAMC in further enhancing palliative care services?

The purpose of this exploratory management project is to apply strategic management planning tools to examine palliative care services at the MVAMC and to identify where the current levels of services are optimal and where changes are indicated. The existing services in palliative care at the MVAMC were created and championed by practitioners with an interest in this area. These practitioners have effected these changes with administrative support for implementation but without administrative support for planning. A system-wide examination using organizational planning tools can identify gaps in palliative care and create a replicable foundation for administrators to make decisions regarding current or enhanced palliative care services.

### Methods

The hypothesis of this applied management project was that utilizing strategic planning tools would result in recommendations for configurations of palliative care services that differ from the level of palliative care currently offered by the MVAMC. The method of the study was a descriptive study of the current state of palliative care at the MVAMC, current directions from the DVA, and an analysis of potential for change. A convenience sample of highly experienced staff received an anonymous survey regarding opinions about MVAMC end-of-life care. Interviews of leaders at the MVAMC and staff from other locations were conducted in person, via telephone, and e-mail. This management project used strategic planning tools in order to identify methods for enhanced palliative care services at the MVAMC.

### *Strategic Management Tenets*

Strategic management models in health care allow for a systematic and replicable application of health care policy at the organizational level (Ginter, Swayne, & Duncan, 2002). These models allow for planning that is based on the vision, values, and mission of the organization. Strategy laid out in a disciplined format eliminates haphazard planning and increases the chances of successful implementation (Ginter, Swayne, & Duncan, 2002). Formal strategic planning allows for follow-up analyses and adjustments if desired outcomes are not achieved.

### *Steps in Strategic Planning*

Strategic planning utilizes a situational analysis, integrating the analyses of the external environment and the internal environment with the organization's mission, vision, and values (Ginter, Swayne, & Duncan, 2002). The external environmental analysis consolidates multiple sources of information, including community conditions, local standards in palliative care, DVA directives regarding palliative care, and standards of palliative care (see literature review). The service area analysis is incorporated in the external environmental analysis and examines the political climate in Minnesota. Ginter, Swayne, and Duncan (2002) suggest that the external environmental analysis describes what the organization should do. The internal environmental analysis examines the internal resources of the organization, identifying what the organization is capable of doing. This analysis includes an examination of the culture for palliative care, staff opinion, and resources available for implementing palliative care initiatives. The directional strategies, specifically the mission, vision, and values statements illustrate what the organization wants to do. The synthesis of these elements forms the basis of a

review of the strengths, weaknesses, opportunities, and threats (SWOT) at the MVAMC and the foundation for the formulation of strategic alternatives.

Data sources for this study include metropolitan area demographics, the political climate, patient demographics, and current service profiles for patients receiving end-of-life care at the MVAMC. The service area analysis incorporates data from the state of Minnesota regarding access to health care and end-of-life services for citizens of the state. Organizational descriptors for the MVAMC are included in the analysis, as well as the relevant organizational resources of the VHA. A stakeholder analysis of internal stakeholders (staff and patients) incorporates recent results from polls of staff and patients' families regarding end-of-life care.

An analysis of directional strategies examines the concordance between currently intended strategy (i.e., highest quality care in the end-of-life for veterans) and the realized strategy. This information along with the mission, vision, and values of the organization forms the basis for strategy formulation. Data from employee interviews were needed to fully analyze any discrepancies between intended versus realized strategy. Ultimately, strategic alternatives emerged from this analysis giving management the platform to stage decisions for palliative care services.

No institutional review board (IRB) approval was required for this study as data were primarily derived from secondary sources, with the exception of the SWOT analysis survey of key employees (n=12), and selected interviews with staff (n=9). The purpose of the project was explained to people that participated in the employee interviews and participation was voluntary.

*Hypothesis of this Study*

The hypothesis of this study was that the use of strategic planning tools would result in suggestions for a different level of palliative care services than the level currently delivered. At the MVAMC, a large percentage of patients that die in the hospital die in the ICUs. A number of those patients and their families may be better served by alternative palliative care services (e.g. a palliative care inpatient unit). There are a number of quality of care and ethical considerations associated with providing patients with the most dignified and high quality experience at the end-of-life. Additionally, studies of cost effectiveness suggest that enhanced palliative care services result in significant medical cost savings. Palliative care has the potential to positively impact health care costs, quality, and access.

The planning for an institution wide approach was a two-step process. First, practitioners at the point of service noted gaps in services and responded to those gaps in the clinical arena while simultaneously calling the gaps to management's attention. This has resulted in the current level of palliative care service. Next, through this project, administrators initiated a formal, replicable surveillance and planning process in order to respond to institutional needs.

### Results

*External Environmental Analysis*

Two major goals of external environmental analysis are to identify and analyze current important issues and to identify emerging trends (Ginter, Swayne, & Duncan, 2002). In analyzing the external environment, three broad factors are examined: the general access to health care in Minnesota, political factors affecting health care, and the

estimated efficiency of current health care services. Next, the specific environment for palliative care in Minnesota is examined. Finally, information is included from another VA medical center of comparable size and mission, which already has progressive and well-developed palliative care services.

Studies of the local health care community indicate that that the citizens of Minnesota experience better than average access to health care services, as compared to national figures. Access to health care is highly correlated with health insurance coverage, and Minnesota, in 2002, had the lowest rate of uninsured citizens in the nation (U.S. Bureau of the Census, 2003). Minnesota's 2002 rate of uninsured citizens (8.8%) was significantly lower than the national average of 17.2%. Minnesota's citizenry had higher levels of private health insurance (40%) than the national average of 37%. Of the 23 billion dollars spent in Minnesota on health care in 2002, 58% came from private sources and 42% came from public sources. There are recent indications that Minnesota is slipping from the position of relatively greater levels of private health care coverage than the rest of the nation (Minnesota Department of Health, 2004). In Minnesota, as in the nation, public spending growth for health care expenditures was greater in 2002 than private spending growth. In Minnesota, the rapid rise in spending in the public sector is related to a slow economy and the associated numbers of low-income citizens enrolling in public health care programs (Minnesota Department of Health, 2004).

The Minnesota Department of Health's estimates of the state's rate of uninsured are lower than the U.S. Bureau of the Census' estimates due to different methodology. A series of recent trends suggests a dynamic and changing picture (see Figure 1). The Minnesota Department of Health has noted a statistically significant trend in growing

rates of uninsured between 2001 (5.4%) and 2004 (6.7%). During that same period of time Minnesota's employer based coverage decreased from 69.7% in 2001 to 63.4% in 2004, and enrollment in public health care programs increased from 20.1% in 2001 to 25.2% in 2004 (Minnesota Department of Health, 2005). Economic factors and a changing political climate are impacting the mix of public to private payer in Minnesota, and elected officials are making a strong push to contain costs.

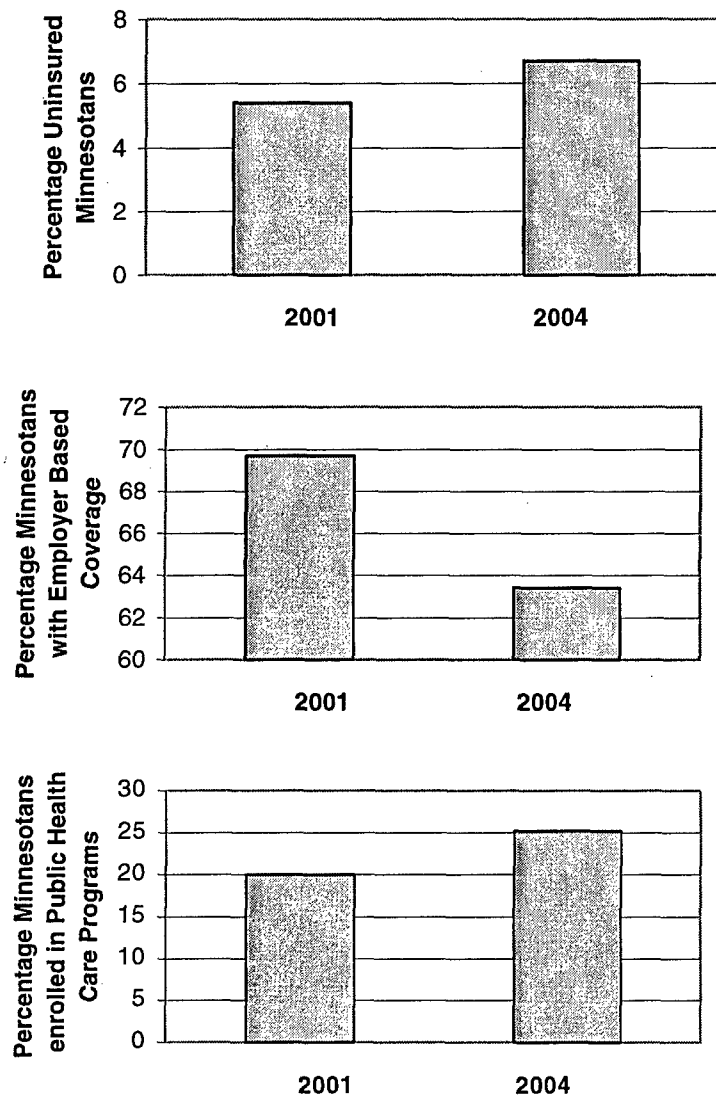


Figure 1. Comparison of multiple trends in insurance coverage in Minnesota

With regard to a changing political climate, Minnesota has historically been a state dominated by the Democrats for Labor (DFL) party. However, in the last two gubernatorial elections, Minnesota voters elected non-Democrats for governor. In 1998, a candidate from the Reform Party (Jesse Ventura) was elected governor. In 2002, a candidate from the Republican Party (Tim Pawlenty) became governor. It is noteworthy that Governor Pawlenty's platform was one of fiscal conservatism. In the current lean economic times, Governor Pawlenty has proposed to remove all adults (except adults designated as disabled) from Minnesota Care, a health insurance program available at discounted rates through state subsidies. The coverage is available to be purchased by Minnesotans that do not have employer-sponsored health insurance. While Governor Pawlenty is proposing cuts in state subsidized coverage for people he describes as able bodied, he is also proposing a more multi-dimensional approach to containing health care costs. In 2003, the governor established a citizens' forum to provide recommendations to his office and the state legislature on health care reform (Listening to Minnesotans: Transforming Minnesota's health care system, 2004). Additionally he has established a "Health Cabinet" to address rising health care costs (Maximum Strength Health Care, 2005).

The recommendations from the Minnesota Citizens' Forum on Health Care Costs were far reaching, and covered many elements of health care, including issues of full disclosure of costs and quality, reducing overall health care costs through improved quality, incentive systems to encourage health, and universal access. A review of these government-initiated forums indicates the future of health care in Minnesota will be

improved quality, improved efficiency, and reduced costs (Listening to Minnesotans: Transforming Minnesota's health care system, 2004). Better palliative care is one way to improve quality and simultaneously reduce costs (Cowan, 2004; Elsayem, Swint, Fisch, Palmer, Reddy, Walker, et al., 2004; Walsh, 2004). It will be increasingly emphasized in the state of Minnesota, as consumers partner with the state government to contain health care costs while maintaining quality.

Current efforts by a private insurer illustrate the health care environment in the state of Minnesota. Blue Cross Blue Shield of Minnesota covers nearly one third of all privately insured Minnesotans and has begun a controversial plan to link reimbursement levels to a combination of factors that measure both quality and efficiency (Olson, Tosto, & Nelson, 2005). While the presence of a palliative care program in a hospital is not one of the initial indicators to be measured and linked to level of reimbursement, pain management programs are in the first wave of criteria to be used to judge hospitals and pain management is a fundamental part of the palliative care approach. Given the robust literature supporting palliative care as a high quality and efficient way of treating patients with chronic and incurable illnesses, palliative care programs are likely to be included in upcoming criteria. Moreover, Minnesota state employees are covered by a health plan that has used a two-tiered reimbursement system for several years. This program has been credited with saving the state millions of dollars, without sacrificing quality in care (Olson, Tosto, & Nelson, 2005). Thus, efficiency in health care services and value in health care expenditures appear to be standards shared by leaders in Minnesota government and industry.



Clearly, Minnesota is doing a significantly better than average job (compared to national figures) of creating access to health care services through insurance. How efficient is Minnesota in health care expenditures? There are three key indicators that help to answer this question. Two of these indicators are illustrated in Tables 1 and 2. In 2002, Minnesota spent 12.5 % less on health care costs per person than the national average. Additionally in 2002, Minnesota spent a smaller share of the state's total economy on health care expenditures, as compared to the portion of the nation's economy devoted to national health care expenditures (Minnesota Department of Health, 2004). Minnesota's per capita hospital expenditures in 1998 were \$1254. Minnesota's per capita hospital expenditures from 1991 through 1998, presented as a ratio to the national per capita expenditures, were .89 (National Center for Health Statistics, 2004). Since this ratio indicates the per capita hospital expenditure in Minnesota is below the national average, and Minnesota is the state with the greatest health care access for citizens through public and private insurance (U.S. Bureau of the Census, 2003), the fact that the per capita hospital expenditure is below the national average is remarkable. Minnesota is providing superior access to health care in an efficient and fiscally sound manner.

Table 1

*Per Capita Expenditures on Health Care in Minnesota versus the Nation: Trends Over Time*

	1998	2000	2002
Health Care Spending: Minnesota	\$3346	\$3950	\$4547
Health Care Expenditures: National	\$4041	\$4471	\$5196

Note. This table partially excerpted from the Minnesota Department of Health's 2004 Report: *Minnesota Health Care Spending in 2002*. This report is in the public domain.

Table 2

*Health Care Expenditures as a Portion of the Economy in Minnesota versus the Nation:  
Trends Over Time*

	1998	2000	2002
Percentage of Economy Spent on Health Care: Minnesota	9.9%	10.4%	11.9%
Percentage of Economy Spent on Health Care: U.S.	12.7%	12.8%	14.3%

Note. This table partially excerpted from the Minnesota Department of Health's 2004 Report: *Minnesota Health Care Spending in 2002*. This report is in the public domain. National figures used are based on expenditures for health services and supplies; Minnesota categories are comparable.

The Minnesota Palliative Care Partnership was organized in 1999 by the largest health systems and health insurers in the state. The partnership represented the key community leaders in health care and focused its efforts specifically in the areas of end-of-life care and palliative care services. In a 2003 position paper published by this group, a powerful argument was made for the expansion of palliative care services, through increased insurance coverage and reimbursement for palliative care. The argument made by this group was based on palliative care representing a best practice, lowering costs, and improving quality (The Minnesota Palliative Care Partnership, 2003).

Thus, in examining the external environment impacting the MVAMC, the citizens and elected leaders of Minnesota value high quality health care and efficient health care expenditures. Minnesota is a national leader in access to health care. As the state government increasingly pays for health care, the push towards efficiency will become even more pronounced. The governmental response is to very actively involve citizens in the dialogue about standards of health care. There is a concerted statewide push for

measurable outcomes. Both private and public insurers are linking pay levels to standards of care, including efficiency and quality. The MVAMC collects private insurance when allowed by statute (38 U.S.C.1129) to do so, and, thus, will need to observe and meet all community standards based in quality and efficiency in order to achieve maximum reimbursement. External environmental analyses suggest that the time is ripe for expansion of palliative care services that enhance quality and patient satisfaction while containing costs. The political climate suggests that organizations not fully equipped with health care interventions such as palliative care may face lower reimbursement rates and less third party reimbursement business in the future.

An analysis of the differences between the MVAMC and a VA with well-developed palliative care services yielded important findings. The VAMC in San Antonio Texas, has been expanding its palliative care services since the late 1990s, and has established a palliative care fellowship-training program. According to Dr. Robert Sammel, a former palliative care fellow and now a staff physician at the San Antonio VAMC, the method of delivering palliative care there is multi-dimensional, interdisciplinary, and integrated into medical services in a variety of innovative ways (R. Sammel, personal communication, April 27, 2005). The San Antonio VAMC has dedicated units with a mix of hospice patients (approximately one-half), and cancer patients (approximately one-third), with the remaining beds used for long term care patients or as swing beds. The palliative care specialists engage in active case finding, assuming care of complex pain patients. Many referrals come directly from primary care and surgery. In addition, the palliative care specialists take care of many radiation and oncology patients with complex pain problems both inpatient and outpatient. The

physicians make themselves very visible and attend team meetings in oncology, ear/nose/throat (ENT), and other medical specialties. The social worker that serves oncology is also the palliative care team social worker; thus, patients that can benefit from palliative care are identified early in the context of their care in oncology. The palliative care fellow also works directly in the oncology clinic. The palliative care team in San Antonio accepts people receiving chemotherapy or radiation to extend life, as long as it is palliative in nature and accompanied by clear planning about the end-of-life. One of the most unusual features of the approach at the San Antonio VAMC is that primary care providers continue care of cancer patients and use oncologists as consultants only. This may assist the culture at San Antonio in being very oriented towards continuity of care; less aggressive in treatment when appropriate, and very organized in defining treatment goals. An additional unique feature is the outpatient palliative care clinic. Many of the patients seen in the outpatient palliative care clinic are oncology patients who improve and go home but have needs for ongoing symptom management. The ICU staff do their own management of dying patients, and palliative care specialists provide services to the ICUs mainly in the form of ethics consultations.

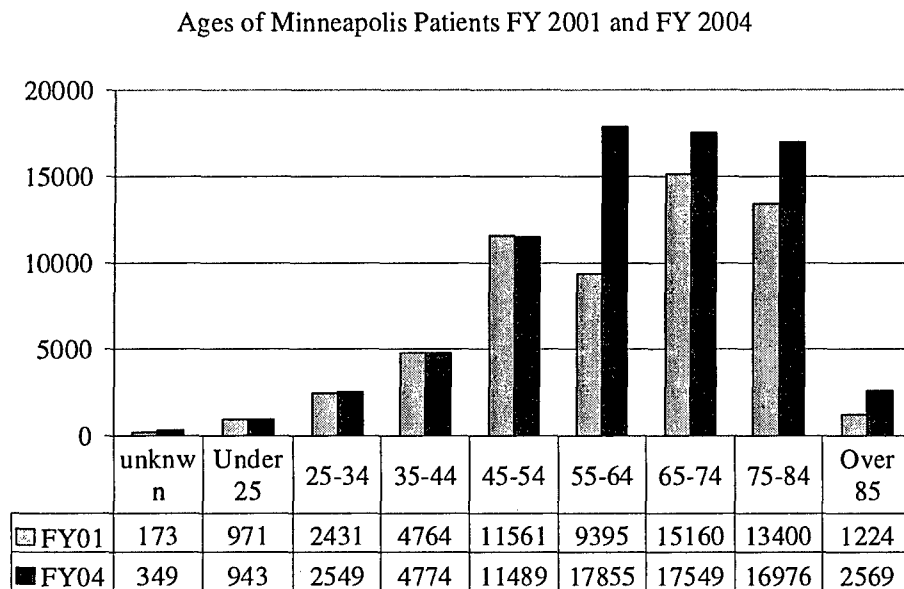
Dr. Sammel believes that the key to the success of palliative care services in the San Antonio VAMC is the integration of the palliative care fellows and allied health staff into multiple venues of care (oncology, geriatrics, primary care). He feels that even more success would result from a palliative care physician being present at tumor boards, having a hospice nurse well versed in both hospice and general palliative care issues, and intervening as early as possible using palliative care methods in the care of incurably ill patients (R. Sammel, personal communication, April 27, 2005).

*Internal Environmental Analysis*

An internal environmental analysis assists planners in understanding what the organization is capable of doing. In traditional strategic planning models, a primary goal of an internal environmental analysis is to develop a competitive advantage (Ginter, Swayne, & Duncan, 2002). While governmental agencies may not be seeking to develop a competitive advantage, analyzing the strengths and weakness of the internal workings of an organization can inform the redesign of models of operation. Additionally, government agencies are being held accountable at ever-increasing levels, and within a particular governmental system, competition for scarce dollars may occur. The VHA allocates money to integrated service networks, in part based on performance on specified financial and performance targets. Thus, understanding an organization's unique strengths and weaknesses is of value in governmental agencies. The VHA receives appropriated funds and is required by congressional mandate to steward those resources efficiently. VHA bills third part payers and is increasingly reliant on efficient billing and collection. Finally, VHA uses performance-based methods to distribute a finite number of dollars to medical centers.

The MVAMC is a 341 bed, university-affiliated, medical center, with 237 acute care beds and 104 extended care and rehabilitation beds; in the extended care inpatient area there are two palliative care suites. The MVAMC provided care to over 73,000 veterans in 2004 and has a growing cohort of aging veterans (Figure 2). The rapidly growing elderly population means that high quality and respectful end-of-life care is imperative for it to be an excellent health care organization that truly serves its constituency. High quality end-of-life care is a requirement in order to appropriately

steward limited resources. However in 2003, the physicians responsible for palliative care service at the MVAMC received only seven palliative care consults (D. Zimmer, personal communication, September 2004).



*Figure 2.* Comparison of ages of MVAMC veterans 2001 and 2004.

There are no board certified palliative care physicians on staff, but there are many physicians who are very skilled and experienced in end-of-life care. Similarly, there are no nurses on staff at the MVAMC with palliative care certification. While the VHA offers palliative care fellowships at select sites, the MVAMC is not a site for fellowship training at this time. Palliative care fellowships offer a method to expand and enhance palliative care services in creative, high quality, and cost effective ways. Thus, the internal environmental analysis suggests that the MVAMC has room to improve formal credentialing as a vital step towards enhanced palliative care services and training.

*Stakeholder Analysis*

A very experienced nurse manager working in the intensive care areas of the MVAMC performed a select stakeholder analysis in 2004 (K. Clutter, personal communication, November 2004). She conducted a poll of both patient satisfaction and staff satisfaction regarding end-of-life care in the ICUs where more inpatient end-of-life care occurs than in any other unit in the hospital. Her results suggested that overall the families of patients' that received end-of-life ICU care were satisfied with the care. Her results also suggested that when families were dissatisfied, the source of the dissatisfaction was inadequate communication. Her results for staff opinions suggested that staff have discipline specific differences in their views of how long to engage in life extending practices. This nurse manager drew several conclusions: excellent communication is essential for end-of-life care in the ICU, standardized protocols for end-of-life care would improve both communication and the care itself, and some effort should be made to create a quieter space in the ICU units for patients that are expected to die in less than 24 hours when withdrawn from life support. Other impressions formed by the ICU nurse manager included the observation that the palliative care culture at the MVAMC is underdeveloped and may account in part for the high death rate on the ICUs (K. Clutter, personal communication, November 2004). Results from the employee survey conducted in connection with this project suggest that many employees see the clinical staff as very dedicated to the concept of high quality end-of-life care, but they would like to see the administrative side of operations do more to make palliative care a priority.

*Directional Strategies*

The MVAMC is part of VSN 23 and the directional strategies for MVAMC match those of VSN 23 and reflect the network goals. The directional strategies (mission, vision, and values) are available in many versions, printed and electronic, from the MVAMC.

- Our Mission: Maintain and improve the health and well being of network veterans.
- Our Vision: Be a patient-centered, integrated organization providing excellence in health care, research, and education. Be an active Federal, State and community partner and a back-up for national emergencies. Be an organization where people choose to work.
- Our Values: Trust, Respect, Excellence, Commitment, Compassion, Empowerment, Continuous Improvement, and Collaboration.

The enhancement of palliative care services would be entirely consistent with directional strategies. There are some weaknesses in the directional strategies. While the mission statement does tell the reader about the identity of the VA, it could apply to any VA. The vision statement should be inspiring and the MVAMC vision statement appears to be primarily an elaboration of the main elements of the mission. That said, the true synchrony between the directional strategies and palliative care lies in the values statement. The tenets of palliative care are founded in respect, trust, compassion, empowerment, and collaboration. Enhanced palliative care is aligned strongly with the values in the directional strategies.



*SWOT (Strengths, Weaknesses Opportunities and Threats) Analysis*

In order to best understand the MVAMC strengths, weaknesses, opportunities, and threats, a SWOT analysis was done by integrating the external and internal environmental analyses with the directional strategies and by gathering more gap analysis information via employee survey. This survey was distributed to employees that supervise and provide clinical care to patients. The employees targeted for this survey worked in areas with a high probability of providing care to patients with chronic, incurable illnesses. Thus, this survey was distributed in areas such as extended care, intensive care, and hematology-oncology. The surveys were entirely anonymous and voluntary (n=12; Appendix C). Staff that worked in the area served as the distribution and collection agents for the survey. The intention of the survey was to sample from a small, highly select group of people that are knowledgeable and experienced in end-of-life care, and likely to have opinions about how to best care for patients with chronic, incurable illnesses.

Additionally, executive leadership at the MVAMC was asked to comment on the operational challenges ahead that might impact palliative care (n=4). Finally, leadership in key areas providing end-of-life care was interviewed as to the culture for palliative care, perceived barriers to palliative care, and perceived opportunities for enhancement of palliative care (n=5).

Results from the survey and from interviews with executive leadership suggested important strengths weaknesses, opportunities, and threats (SWOT) with regard to palliative care services. A compilation and classification of the results of the SWOT analysis is located in Table 3. Barriers to palliative care are classified as internal

weaknesses or external threats. The analysis suggested that the most important barriers included a lack of a palliative care culture, coupled with the presence of a culture of aggressive curative care -- no one staff person identified as the palliative care leader, no board certified specialists in palliative care, confusion about palliative care methods, general discomfort with end-of-life care, and no VHA wide performance measures of palliative care. Other important barriers included poor representation of pain management services in general; limited access to the current palliative care beds; and shortages of resources, including inpatient beds and nursing staff. Major opportunities identified included a highly respected clinical champions promoting improved end-of-life care, great staff appreciation of the palliative care suites, VHA sponsored palliative care fellowship programs, and VHA wide recognition that palliative care needs to be improved (Table 3).

#### *Overview of the Current Strategy*

The main question facing the MVAMC today is whether to continue with the existing model of palliative care or to expand or modify services. The palliative care currently delivered at the MVAMC has developed from talented and experienced staff demonstrating front line leadership in developing and implementing ideas. This is illustrated in large part by the creation of the two palliative care suites. Similarly, capable and experienced staff involved in intensive care initiated studying and developing ideas about palliative care in the ICU areas. The approach to palliative care at the MVAMC has grown organically, based on staff interest and expertise. This is often an excellent way for clinical services to grow, as it demonstrates an empowered front line staff able to effect

Table 3

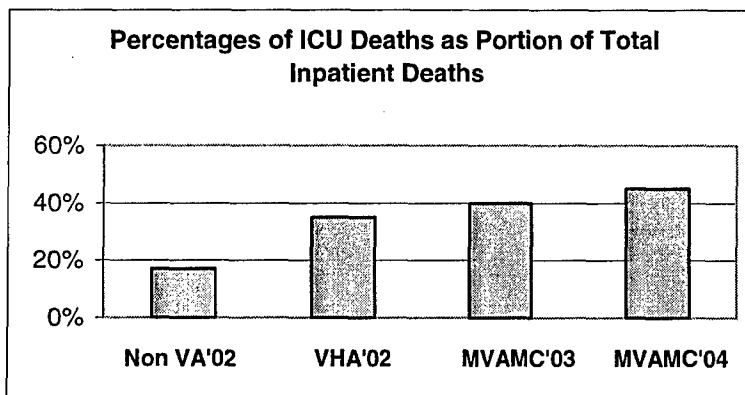
*SWOT Analysis for Enhanced Palliative Care Services at the MVAMC*

<p style="text-align: center;"><b>Internal Strengths</b></p> <ul style="list-style-type: none"> <li>• Significant staff interest in improving end-of-life care with several clinician champions across venues including ECC and ICUs</li> <li>• Local control of decisions about bed allotments</li> <li>• Long-term bed capacity at MVAMC</li> <li>• Strong support among clinical providers for psychosocial interventions</li> <li>• Current availability of 2 beds for palliative care on ECC</li> <li>• Clinical staff dealing with end-of-life issues is exceptionally dedicated to excellence in caring for their patients</li> <li>• Flexibility to provide much family education and support</li> <li>• Current extended care area that house palliative care patients tends to provide very good continuity for patients</li> <li>• Presence of the palliative care suites has raised the profile of palliative care in the hospital</li> <li>• Staff very interested in increased education in this area</li> <li>• Strong research presence presents great opportunity for measuring improvements</li> <li>• Very caring clinical staff working with palliative care patients</li> <li>• Good competence with advance directives</li> <li>• Excellent chaplain service</li> <li>• Full range of interdisciplinary services could be trained in palliative care</li> </ul>	<p style="text-align: center;"><b>Internal Weaknesses</b></p> <ul style="list-style-type: none"> <li>• Very limited inpatient beds</li> <li>• Lack of board certified specialists in palliative care</li> <li>• Tertiary care culture of aggressive, cutting edge, curative medical care</li> <li>• Research and clinical staff very interested in aggressively treating and studying end stage illness</li> <li>• No pain management team</li> <li>• Lack of input on end-of-life care from crucial providers such as anesthesia and pharmacy</li> <li>• Lack of clarity about palliative chemotherapy and radiation in end-of-life care (staff feel there may be prohibitions against this as a palliative technique)</li> <li>• Many staff not comfortable with complex pain control procedures (e.g. nerve blocks, morphine pumps)</li> <li>• Do not have the most up to date pain treatments</li> <li>• Can only admit to palliative care beds Monday through Friday during the day</li> <li>• Limited funds for capital improvements</li> <li>• Physicians, residents, and nurses in the acute care areas may be less familiar with pain control for end-of-life care</li> <li>• Despite strong need, palliative care suites are not always filled</li> <li>• Most palliative care duty assignments are collateral rather than dedicated assignments</li> <li>• Failure to identify palliative care patients early</li> <li>• No one person spearheading an institution-wide palliative care effort</li> </ul>
<p style="text-align: center;"><b>External opportunities</b></p> <ul style="list-style-type: none"> <li>• VHA standardized programs for improving end-of-life care available through web based training applications</li> <li>• VHA sponsored palliative care fellowships</li> <li>• MVAMC is part of a system with sister institutions with well developed programs</li> <li>• Development of multi-disciplinary teams based on models incorporating physician, nursing, pharmacy, social work, psychology, and clergy</li> <li>• Flexibility to contract in the community with hospice agencies as needed</li> <li>• VHA has stated palliative care is a critical mission</li> </ul>	<p style="text-align: center;"><b>External Threats</b></p> <ul style="list-style-type: none"> <li>• Third party reimbursement streams may align most with aggressive curative care</li> <li>• No national VHA performance measure that specifically addresses palliative care</li> <li>• Nursing shortage in the community and in the nation</li> <li>• Small number of palliative care specialists in the nation and most are concentrated around where they have studied</li> <li>• Lack of a national consensus about acceptable therapies in palliative care</li> </ul>

Note. The information in this table is based in part on aggregated feedback from an employee survey, select employee interviews, and feedback from the executive leadership at the MVAMC

changes as needed in the system. However, there has been less planning across functional areas. Prevailing staff opinion is that the institutional culture does not include an emphasis on palliative care.

A review of inpatient deaths at the MVAMC in Fiscal Year (FY) 2004 demonstrates that 45% of all deaths occurred in the ICUs and that 24% occurred in the hospice area of the extended care units (ECC). This is an increase from the year before and is higher than national VHA and Medicare comparisons (VHA Office of Academic Affiliations, 2002; Figure 3). The average total cost per day in the MICU is \$4033, in the SICU is \$3415 and in the ECC is \$920. The average total cost per day, averaged across both ICUs, is \$3724, which is over four times the average total cost per day in the extended care units.



*Figure 3.* National and local comparisons of percentages of inpatient ICU deaths as a portion of total inpatient deaths for non-VA care, national VA care, and MVAMC care.

### *Strategic Alternatives*

In examining the external and internal environments and aligning with directional strategies, there is little doubt that enhancement (specifically expansion) of palliative

cares services would be consistent with the mission, vision, and values; possible within the capabilities of the internal environment; and desirable with regard to the external environmental climate. Using the information developed in the SWOT analysis, a TOWS (Threats, Opportunities, Weaknesses, and Strengths) matrix was developed to illustrate the future quadrant, internal fix-it quadrant, external fix-it quadrant, and the survival quadrant (Appendix D). The TOWS matrix is helpful in cross referencing the internal and external challenges and strengths to devise the most realistic or efficient methods of improvement.

While the time is right for expansion of palliative care services, how should the services be expanded? In the current fiscal climate, the fact that palliative care could potentially save dollars, or at least be cost neutral, is critically important. Simply opening more beds in palliative care does not guarantee efficient utilization.

Discussions with staff from VA medical centers of comparable size and mission that have more extensively developed palliative care services may inform models of care appropriate to the MVAMC. From 2002 until 2006, the DVA is offering fellowships in palliative care at 6 locations including Palo Alto, Bronx, Los Angeles, Milwaukee, Portland, and San Antonio. All but one of the medical centers chosen, are categorized by the VHA in the same group (per parameters of patient volume, patient complexity, and teaching mission) as the MVAMC. These fellowships are designed as inter-professional fellowships and each location may train up to 4 people per year. The purpose is to develop leadership in the area of palliative care and to help the entire organization move forward with improved end-of-life care (VHA Office of Academic Affiliations, n.d.). This is a ready opportunity for assistance in expanding palliative care services.

The TOWS matrix suggests multiple strategies for enhanced palliative care services. Retrenchment approaches include improving staff credentialing. Diversification strategies include establishing a palliative care fellowship, promoting active palliative care case finding, and reconsidering models of care, including the role of oncologists as opposed to that of primary care doctors in oncology care. Enhancement strategies include educating employees on the importance of planned end-of-life services and broadening the concept of palliative care to cross-geographic boundaries in terms of continuum of care (inpatient to outpatient) and medical specialty (Appendix D).

### Conclusions and Recommendations

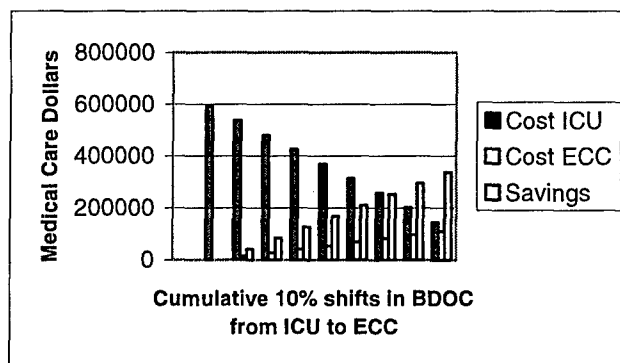
The many options that exist with regard to expanding palliative care are promising. Expanded palliative care offers enhanced quality and possible cost savings. This study identified new approaches, barriers to change, recommendations for change, and suggested strategic alternatives. The information from the MVAMC suggests room for improved quality for end-of-life care, improved utilization, and improved cost savings. This could readily be accomplished through staff training, establishment of a fellowship, and rethinking medical care models.

An external analysis suggests that the MVAMC should expand palliative care services. Doing so will improve care and likely reduce costs, but simply opening more palliative care beds will not address effectively the barriers at the MVAMC. The current culture and the segregation of palliative care to the extended care areas of the hospital do not aid in early identification of patients in other parts of the hospital who will most benefit from palliative care services.

The model used by the San Antonio VAMC could readily be applied at the MVAMC. Key factors for the program's success in San Antonio include integrating palliative care expertise into early medical decision-making in medical specialty areas, such as oncology and primary care; the use of a high visibility approach; and a willingness to cross inpatient and outpatient boundaries. The presence of a palliative care fellowship means that treatment will be state of the art and training will attract people interested in developing expertise in this area. Palliative care fellows will also provide a less expensive way of treating more patients, maintaining high visibility among many medical specialties, and assisting with active case finding.

There are persuasive arguments, based on quality and cost, to be made for increasing access to palliative care services at the MVAMC. In 2002, a VHA study indicated that VAs across the nation average a 35% rate of inpatient deaths on ICUs (as part of a total percentage of inpatient deaths). Medicare patients in non-VA hospitals average a 17% rate of inpatient deaths on ICUs (VHA Office of Academic Affiliation, 2002). In the MVAMC, the average rate of inpatient deaths in the ICUs in FY 2004 was 45%. End-of life care will have enormous financial implications for the VHA nationally and for the MVAMC locally. Data from the MVAMC in 2004 are dramatic, suggesting a four-fold differential between average total costs per day incurred in the ICUs verses in the ECC. In 2004, 204 inpatients died in the MVAMC. A small adjustment in the proportion of patients receiving their end-of-life care in the ECC rather than in an ICU could result in substantial cost savings. To illustrate this point, in the first quarter of FY 2005, 19 patients died in the ICUs, together these patients used 159 ICU bed days of care (BDOC). A scenario analysis in Figure 4 reveals possible cost savings associated with

altering the proportion of patients receiving end-of-life care in the ICU versus the ECC. It examines shifting bed days of care in 10% increments from the ICU to the ECC, resulting in calculated savings, assuming all other things equal. A reduction of 25% of BDOC from the ICU to ECC in the first quarter of FY05 would have resulted in savings of over \$112,000; extending this for the year results in savings of \$450,000. These calculations are destined to be underestimates of cost reductions, as it is unlikely that patients would use as many total bed days of care when they are withdrawn appropriately from life extending treatment.



*Figure 4.* Medical care dollars spent on end-of-life care with BDOC shifting in 10% increments from ICU to ECC and associated savings.

Palliative care barriers identified by staff include a culture of aggressive medical care, inability to admit to palliative care beds around the clock, and a lack of beds on the medical units. While more palliative care beds appear needed, opening more without changing the institutional culture may well result in less than optimal utilization.

Nationally, physician and nursing certification in hospice or palliative care is very unevenly distributed. Although the numbers are small overall, there are high



concentrations in certain facilities or areas (DVA, 2002). The Minneapolis VAMC may have a number of staff interested in certification in palliative care and the development of a fellowship-training site, given the dedication of the staff to the training mission.

Interest expressed by the nursing and physician leadership in palliative care in the ICUs offers a unique opportunity. Recent studies have demonstrated significant cost reductions in using a specialized palliative care unit and team for end-of-life care. Patients dying in such units had total costs that were 57% lower than matched controls dying on other inpatient units in the hospital. The authors in this study indicated that appropriate standardized care is part of what constituted the costs savings (Smith, et al., 2003). Nurses in the ICUs at the MVAMC are requesting standardized end-of-life protocols (K. Clutter, personal communication, November 2004). The introduction of a standardized protocol on an ICU will most importantly improve quality of end-of-life care and may also save costs, or be cost neutral.

Ultimately, the largest quality boost and cost savings would likely result from promoting the culture of palliative care culture hospital wide, and bringing a visible palliative care presence to key specialty areas of medicine. The most cost effective ways to do this are to train interested staff, with a long-range plan of having certified experts that can support an on-site palliative care fellowship program.

The VA has an unacceptably high proportion of inpatient deaths on ICUs, and the MVAMC, in 2004, exceeded the VHA national average. This may indicate some positive system characteristics, such as an ICU staff that provides continuing care for patients when they are withdrawn from life support and are imminently facing death. Conversely, this high percentage of deaths occurring on the MVAMC ICUs may also indicate some

undesirable issues, such as a lack of appropriate bed availability in other inpatient areas, an institutional culture of engaging in aggressive, life-extending treatments beyond what is reasonable, and a related failure to recognize the importance of palliative care much earlier in a patient's course of treatment.

This project demonstrates the utility of using formal strategic planning principles as a solid foundation for planning clinical service operations. The results of this study suggest that the MVAMC must develop enhanced palliative care services in order to fulfill its mission, meet VHA requirements, and compete in the local health care market in terms of quality and efficiency. The MVAMC staff has the expertise, but not the related certification, to become a training center for palliative care. An academic focus on palliative care would result in challenging the already well-established academic culture of aggressive medical care. Additionally, introducing a palliative care training program would attract committed staff, and create interdisciplinary training opportunities. A palliative care fellowship would provide staff and increase visibility, making possible the two key elements (case finding and integration into other medical specialty areas) required for success in creating a culture supportive of palliative care.

#### Limitations of this Study

This form of qualitative and descriptive research is subject to a number of biases. Assumptions of the investigator direct the type of information used in the various analyses. As with other forms of exploratory research, intuitive elements form the early phases of investigation and are helpful in pulling information together and crystallizing ideas (Cooper & Schindler, 2003).

This study sampled a very small group of opinions from people in direct care and the highest level of management. Using observational methods such as surveys to understand the current state of services carries with it the danger of significant investigator and respondent bias. The questions chosen by the investigator greatly influence the answers received. Building in explicit assumptions can mitigate damages caused by experimenter bias. Explicit assumptions and explicit statements of area of emphasis allow for future investigators to alter elements and assumptions to determine the impact of those assumptions.

In this study, the small numbers of clinical staff sampled worked in areas providing end-of-life care. This approach left out many staff that may have excellent and novel ideas regarding palliative care options. Leadership was heavily sampled in this study, but administrative areas such as environmental management and adjunctive services such as pharmacy were not part of this study. This may result in planning that is vulnerable to gaps based on a lack of input from the full spectrum of medical center operations.

### Disclaimer

The views expressed in this paper solely represent the views of the author and do not represent the views of the Department of Veterans Affairs, the Department of Defense, Baylor University, or the University of Minnesota. This study was exempt from IRB review (Appendix B).

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## Appendix A

## VHA Definitions

**Palliative Care:** refers to the comprehensive management of the physical, psychological, social, spiritual, and existential needs of patients with incurable, progressive illnesses. Palliative Care affirms life and regards dying as a natural process that is profoundly personal for the individual and family. The goal of palliative care is to achieve the best possible quality of life through relief of suffering, control of symptoms, and restoration of functional capacity while remaining sensitive to personal, cultural, and religious values, beliefs, and practices.

**Palliative Care Services:** refer to the care of patients with terminal diagnoses or advanced, progressive, incurable illness that are receiving care through VHA. Palliative services are delivered in a variety of settings, including acute care, long-term care, home care, and hospice.

**Hospice:** is a coordinated program of palliative and supportive services provided in both home and inpatient settings for persons in the last phases of an incurable disease so that they may live as comfortably as possible. The program emphasizes management of pain and other physical symptoms, the management of psychosocial problems and spiritual comfort of the patient, the patient's family or other primary care person. Services are provided by a medically directed interdisciplinary team of health care providers and volunteers. Bereavement care is available to the family following the death of the patient. Hospice services are available 24 hours a day, seven days a week. It is important to recognize that

hospice care requires the acknowledgement of the patient, the family, and the physician that the illness is terminal and a mutual agreement that aggressive treatment be terminated.

(Department of Veterans Affairs [DVA], 2002, p. 8)

Appendix B  
Institutional Review Board (IRB) Exemption Letter

Department of  
Veterans Affairs

**Memorandum**

Date: 5/24/05

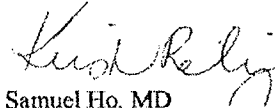
From: Chair, Institutional Review Board (IRB)

Subj.: Anonymous Staff Survey with regard to Palliative Care Services

To: Marci Mylan, PhD

1. Your request to provide MVAMC staff with a survey that is voluntary and completely anonymous was received by the IRB. It was determined that this study does **not** meet the criteria for Human Subjects Research based on the fact that this study involves the use of completely de-identified surveys with no available link, and therefore, PHI is not involved in this research.

2. Should anything in your study design change, specifically the obtaining of links to PHI or direct PHI corresponding to these samples, you must re-submit your protocol to the IRB for approval.



/ Samuel Ho, MD

## Appendix C: Staff Survey

**Provider Survey on Palliative Care**  
*This survey is anonymous and voluntary*

In filling in the blanks below, think about what we offer here at Minneapolis in terms of Palliative Care; what we could or should be doing, what worries you about the palliative care we provide, and what barriers there might be to improving our palliative care. For your assistance a definition of palliative care is included at the bottom of the page.

<b>Strengths at MVAMC in palliative care:</b>
<b>Weaknesses at MVAMC in palliative care:</b>
<b>Opportunities at MVAMC for enhanced palliative care services</b>
<b>Barriers at MVAMC to enhanced palliative care services</b>

**VHA Definition of Palliative Care:** The comprehensive management of the physical, psychological, social, spiritual, and existential needs of patients with incurable, progressive illnesses. *The goal of palliative care is to achieve the best possible quality of life through relief of suffering, control of symptoms, and restoration of functional capacity* while remaining sensitive to personal, cultural, and religious values, beliefs, and practices.

*This survey is part of a management project being conducted by Marci Mylan, PhD. Survey results will be shared with the Executive Team in Minneapolis VAMC and will be included in a management project report to Baylor University*

## Appendix D: Threats Opportunities Weaknesses Strengths (TOWS) Matrix

	<b>Internal Strengths</b> <ul style="list-style-type: none"> <li>• Significant staff interest in improving end-of-life care; clinician champions across venues</li> <li>• Local control of decisions about bed allotments</li> <li>• Long-term bed capacity at MVAMC</li> <li>• Clinical staff dealing with end-of-life issues is exceptionally dedicated to excellence in caring for their patients</li> <li>• Flexibility to provide much family education and support</li> <li>• Presence of the palliative care suites has raised the profile of palliative care in the hospital</li> <li>• Staff very interested in increased education in this area</li> <li>• Strong research presence presents great opportunity for measuring improvements</li> <li>• Very caring clinical staff working with palliative care patients</li> <li>• Good competence with advance directives</li> </ul>	<b>Internal Weaknesses</b> <ul style="list-style-type: none"> <li>• Very limited inpatient beds</li> <li>• Lack of board certified specialists in palliative care</li> <li>• Tertiary care culture of aggressive, cutting edge, curative medical care</li> <li>• Research and clinical staff interested in aggressively treating, studying end stage illness</li> <li>• Lack of input on end-of-life care from crucial providers such as anesthesia and pharmacy</li> <li>• Lack of clarity about palliative chemotherapy and radiation in end-of-life care (staff feel there may be prohibitions against this as a palliative technique)</li> <li>• Can only admit to palliative care beds Monday through Friday during the day</li> <li>• Most palliative care duty assignments are collateral</li> <li>• Failure to identify palliative care patients early</li> <li>• No one person spearheading an institution-wide palliative care effort</li> </ul>
<b>External Opportunities</b> <ul style="list-style-type: none"> <li>• VHA standardized programs for improving end-of-life care available through web based training applications</li> <li>• VHA sponsored palliative care fellowships</li> <li>• MVAMC is part of a system with sister institutions with well developed programs</li> <li>• VHA has stated palliative care as a critical mission</li> </ul>	<b>Future Quadrant</b> <ul style="list-style-type: none"> <li>• <u><b>Related Diversification</b></u> Establishing a palliative care fellowship program</li> <li>• <u><b>Market Development</b></u> Become a center of excellence in palliative care</li> <li>• <u><b>Related Diversification</b></u> Use the Consumer Advisory Board at the MVAMC to plan for the highest quality end of life services</li> </ul>	<b>Internal Fix-It Quadrant</b> <ul style="list-style-type: none"> <li>• <u><b>Retrenchment</b></u> Encouraging qualified dedicated staff to pursue palliative care certification</li> <li>• <u><b>Enhancement</b></u> Support a model of palliative care that cuts across specialty boundaries &amp; integrates palliative care specialists with other medical teams; use a local performance standard</li> <li>• <u><b>Enhancement</b></u> Begin an aggressive campaign with employees to educate regarding palliative care and principles of excellence in end-of-life care</li> <li>• <u><b>Related Diversification</b></u> Broaden MVAMC palliative care model to include outpatient services &amp; case finding</li> </ul>
<b>External Threats</b> <ul style="list-style-type: none"> <li>• Third party reimbursement streams may align most with aggressive curative care</li> <li>• No national VHA performance measure that specifically addresses palliative care</li> <li>• Nursing shortage</li> <li>• Small number of unevenly distributed palliative care specialists in the nation</li> <li>• Lack of a national consensus re: acceptable therapies in palliative care</li> </ul>	<b>External Fix-It Quadrant</b> <ul style="list-style-type: none"> <li>• <u><b>Penetration</b></u> Identify key staff that could work with hospice contracts serving patients outside of the hospital and inside of the hospital</li> </ul>	<b>Survival Quadrant</b> <ul style="list-style-type: none"> <li>• <u><b>Enhancement</b></u> Palliative care fellowship could result in attracting both nurses and certified physicians to local VA employment</li> </ul>